# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

★ 09669 Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. U.S. Naval High Power Radio Station.
(If rural give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dennis E. Ackley

3.(b) Social Security Number

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | — |

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-46

8. AGE: Years | Months 2 | Days 5 | If less than one day hrs. min.

9. Birthplace Annapolis, Anne Arundel, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name William Bernard Ackley.
13. Birthplace Plains City, Ohio. 1/4/22

MOTHER
14. Maiden name Irene Galloway
15. Birthplace Lorain, Ohio. 11/22/24

16. Informant William B Ackley
Address annapolis. md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 21/46 (month) (day) (year)
Cemetery or crematory Naval Cemetery
Location Annapolis. Md

18. Funeral director B. L. Hopkins & Son
Address Annapolis. Md.

19. Oct. 21, 1946 (Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1946, at 12 30 P. M

21. I CERTIFY that death occurred on the date above stated. Post mortem Examination Oct. 18 1946

| | DURATION |
|---|---|
| Immediate cause of death | |
| Strangulation by aspiration of vomitus into tracheo | |
| Due to accident | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-18-46
Where did injury occur? High Power Radio Station (City or town) A.R. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury aspiration of vomitus Injured at work? Deputy medical Examiner

23. SIGNATURE John M. Claffy M.D. M. D. or other
Address Annapolis, Md Date signed 10/18/46

Evidence for addition of usual residence is shown on FILM No. I 08 OCT 31 1946

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

09670

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bay Road
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Baby - Bain

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W. | Single |

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 23rd 1946

**8. AGE:** Years | Months | Days | If less than one day: appx 6 hrs. ..... min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Andrew L. Bain
13. Birthplace: Scotland

MOTHER — 14. Maiden name: Wilhelmene Dynes
15. Birthplace: Union City N.J.

16. Informant: Mrs. Andrew L. Bain
Address: R.F.D. # Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 25th 1946 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Taylor & Son
Address: Annapolis Maryland

19. Oct. 24 1946 (Date rec'd by registrar) — Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23rd 1946, at 12 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-23 1946, to 10-23 1946
and that I last saw him alive on 10-23-46 1946

| Immediate cause of death | DURATION |
|---|---|
| atelectasis | |
| Due to: prematurity | 6 hrs |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

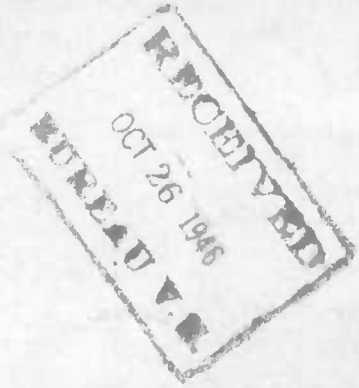
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edith Rodler, M.D.
M. D. or other
Address: 42 State Circle Annapolis Date signed: 10-28-46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name if child is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
OCT 26 1946
BUREAU V.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

09671

Reg. Dist. No. 2n3

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 313 Fort Meade Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Mella Loomis Baldrey

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife: Henry Baldrey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 21 - 1856

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 89 | 11 | 11 | hrs. min. |

9. Birthplace: Fueton, New York
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Alfred Loomis
13. Birthplace: Unknown

MOTHER
14. Maiden name: Vallonia Rosebrook
15. Birthplace: Unknown

16. Informant: Mrs. Harry Pratt
Address: 313 Ft. Meade Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5 1946 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore, Md.
18. Funeral director: J. W. Singleton
Address: Glen Burnie, Md.
19. Oct. 5 1946 (Date rec'd by registrar) Mrs Alba Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1946, at 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1941 to Oct. 5 1946
and that I last saw h[illegible] alive on Oct. 5 1946

| | DURATION |
|---|---|
| Immediate cause of death: Cardio Vascular Disease | 10 days |
| Due to: | |
| Due to: | |
| Other conditions: Bronchial Pneumonia | 2 wks. |
| Arthritis Deformans | 5 yrs. |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Bale M.D.
M. D. or other
Address: Linthicum Date signed: 10-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09672

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Laurel Race Track
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County: Queens
City or town: Rich Hill, Long Island
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 120-18 Liberty Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Barry

3.(b) Social Security Number: Unknown

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: unknown
6.(b) Name of husband or wife: none
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): October 12, 1905
8. AGE: Years: 40 Months: 11 Days: 20 If less than one day: hrs. min.
9. Birthplace: Brooklyn, N.Y.
(Town, county, and state)
10. Usual occupation: Groom
11. Industry or business: Laurel Race Track
FATHER 12. Name: George Barry
FATHER 13. Birthplace: New York, N.Y.
MOTHER 14. Maiden name: Jennie Hanlon
MOTHER 15. Birthplace: New York, N.Y.
16. Informant: Grace Unlaud
Address: 120-18 Liberty Ave. Queens, New York
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 5, 1946 (month) (day) (year)
Cemetery or crematory: Calvary Cemetery
Location: Queens County, N.Y.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md
19. Oct 3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 2, 1946, at 6:13 P.M.
21. I CERTIFY that death occurred on the date above stated: Post mortem Examination Oct. 2 1946
Immediate cause of death: Coronary Embolism — DURATION: sudden
Due to: Coronary Sclerosis — DURATION: unknown
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 10-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09673

Reg. Dist. No. 23

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Odenton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Odenton, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: rifth Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** HARVEY E. BEHRINGER

**3.(b) Social Security Number:** 213-22-1976

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | Married |

6.(b) Name of husband or wife: Mary E. Behringer

Nee Brown 6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): September 29, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 0 | 5 | ...hrs. ...min. |

9. Birthplace: Catasqua, Penna.
(Town, county, and state)

10. Usual occupation: Soldier ( Retired)

11. Industry or business: United States Army

FATHER 12. Name: Francis E. Behringer

13. Birthplace: North Hampton, Pa.

MOTHER 14. Maiden name: Emma E. Graffin

15. Birthplace: Nazerith, Pa.

16. Informant: Mrs. Harvey E. Behringer

Address: Fifth Street, Odenton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: October 8 46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Thomas W. Dingletew

Address: Glen Burnie, Md.

19. Oct 8 (Date rec'd by registrar) 19 46 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 1946 at 6P M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination

~~and that I last saw him alive on~~ ... 19...

| Immediate cause of death | DURATION |
|---|---|
| Acute Dilatation of Heart | sudden. |
| Due to: Cardiac asthma | 2 years |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: John M. Clatty M.D. Deputy Medical Examiner
M. D. or other

Address: Annapolis, Md. Date signed: 10-5-46

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09674

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Years
Hospital, institution, or street address where death occurred: Skidmore Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: Anne Arundel
(For newborn infants give residence of mother)
State: Maryland County: [redacted]
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Skidmore Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Wary Blunt

3.(b) Social Security Number: None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October, [redacted] 1911

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | | | ..... hrs. ..... min. |

9. Birthplace: Penn.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: John Wary
13. Birthplace: Penn.

MOTHER
14. Maiden name: Unkown
15. Birthplace: Unkown

16. Informant: Frank Green
Address: Skidmore Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 10-4- 1946
(month) (day) (year)
Cemetery or crematory: Broad Neck
Location: Skidmore Md.

18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street

19. Oct. 4, 1946
(Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1st 1946 at 4:07 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 29th 1946 to Oct 1st 1946 and that I last saw h[illegible] alive on Oct 1st 1946

| Immediate cause of death | DURATION |
|---|---|
| Bronchial Pneumonia | 10 days. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. F. Rushworth M.D.
M. D. or other
Address: Bowie, Md. Date signed Oct 4 1946

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09675

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs. 10 mo.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 5 yrs. 10 mo.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

**3.(a) FULL NAME:** BORDLEY - ELIZABETH

**3.(b) Social Security Number:** ---

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | black | separated |

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): ---- 1908

8. AGE: Years: 38 | Months: -- | Days: -- | If less than one day: -- hrs. -- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER
12. Name: Isaac West
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachel Brown
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 17, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County

18. Funeral director: George G. Kelson
Address: 1303 Prestman St.

19. Oct 14 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1946 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13 1941, to October 13 1946 and that I last saw her alive on October 12 1946

| Immediate cause of death | DURATION |
|---|---|
| Lung tuberculosis | known to us since April 12, 1945 |
| Due to | |
| Due to | |
| Other conditions: Schizophrenia Paranoid Type (Include pregnancy within 3 months of death) | known to us since Jan. 13, 1941 |

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: Oct. 14,

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-1)

## CERTIFICATE OF DEATH

09676

Reg. Dist. No. 23

Initial

**1. PLACE OF DEATH:**
County: Linthicum Heights
City or town: Anne Arundel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Camp Meade Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Howard Samuel Bovard

**3.(b) Social Security Number:** -

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6.(b) Name of husband or wife: Elizabeth Sharp
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1861

8. AGE: Years: 85 | Months: 7 | Days: 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pittsburg Penna.
(Town, county and state)

10. Usual occupation: Merchant

11. Industry or business: Retired

FATHER
12. Name: Bovard
13. Birthplace: Penna.

MOTHER
14. Maiden name: Mary Jane McCracken
15. Birthplace: Ireland.

16. Informant: Elmer R. Hile
Address: Camp Meade Rd Linthicum Heights

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-13-46 (month) (day) (year)
Cemetery or crematory: Freeport
Location: Freeport, Penna.

16. Funeral director: Wm. J. Tilmer & Son
Address: North & Penna Ave

19. Oct 13 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 1946 to Oct. 12 1946, and that I last saw h... alive on Oct. 12 1946

| Immediate cause of death | DURATION |
|---|---|
| Cardio-Vascular Disease | 2 yrs. |
| Due to | |
| Due to | |
| Other conditions: Arteriosclerosis | 10 yr. |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Ball M.D.
M. D. or other
Address: Linthicum Date signed: 10-12-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

# CERTIFICATE OF DEATH

09677

Reg. Dist. No. 23

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Elmhurst ( Severn Md. P.O.)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Elmhurst ( Severn, Md. P.O.)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** MARY ATLINE BOYER

**3. (b) Social Security Number:** NONE

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: William O. Boyer

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): January 16, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 8 | 21 | ....hrs. ....min. |

8. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: OWN HOME

FATHER
12. Name: Leonard Albert
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Christina Wolfe
15. Birthplace: Baltimore, Md.

16. Informant: William O. Boyer

Address: Elmhurst ( Severn Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 9, 46 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. October 8 1946 (Date rec'd by registrar) M. Talbert Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1946, 2.45A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945, to 10/5/46 19..... and that I last saw h.. alive on 10/5/46 19.....

| Immediate cause of death | DURATION |
|---|---|
| Renal Insufficiency | 6 months. |
| Due to: Chronic Interstitial nephritis | 6 m. |
| Due to: Diabetes. | 1½ years |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? ....(City or town) ....(County) ....(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ....Injured at work?

23. SIGNATURE: Gustave A Bauernschmidt M. D. or other

Address: Glen Burnie, Md. Date signed: 3-28-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T) (I) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

## CERTIFICATE OF DEATH

09678 231
Reg. Dist. No.

**1. PLACE OF DEATH:**
County A. A. Co., Md
City or town Glenburnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Glenburnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. Freetown A. A. Co.
(If rural, give LOCATION)
2.(a) If veteran, name war —

**3. (a) FULL NAME** Carrie L. Brady

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | M |

6.(b) Name of husband or wife James O. Brady
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Sept 17, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | | | ..... hrs. ..... min. |

9. Birthplace A. A. Co. Md (Town, county, and state)
10. Usual occupation Domestic
11. Industry or business

FATHER
12. Name Malachi Cheney
13. Birthplace Md

MOTHER
14. Maiden name Laura Frankhouse
15. Birthplace Md

16. Informant James O. Brady
Address Freetown A. A. Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-46 (month) (day) (year)
Cemetery or crematory Maryland Park
Location A. A. Co. Md

18. Funeral director Isaiah L. Crawford
Address 1082 Broadway

19. 10/24 (Date rec'd by registrar) 1946 C. H. Hessel Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1946 to Oct 20 1946 and that I last saw h[illegible] alive on Oct 20 1946

| | DURATION |
|---|---|
| Immediate cause of death Myocardial Insufficiency | 6 hrs |
| Due to Hypertension | Long duration |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Leon P. Hardy M.D. M. D. or other
Address 4702 Edmondson Ave Baltimore 29 Md Date signed Oct 22 1946

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-6

## CERTIFICATE OF DEATH

09679

Reg. Diat. No. 28

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 7 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 3 months 7 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 27 West Bethel St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

**3.(a) FULL NAME**

BROWN - WALTER DEWEY

**3.(b) Social Security Number**

------

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | married |

6.(b) Name of husband or wife: Mrs. Malcomb Brown

6.(c) If alive, give age ------ years

7. Birth date of deceased (mo., day, yr.): 1898

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 48 | -- | --- | ...hrs. ...min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: ------

FATHER
12. Name: Holden Brown
13. Birthplace: Maryland

MOTHER
14. Maiden name: ------
15. Birthplace: -------

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried
(Burial, cremation, or removal. Which?)
Date thereof: Oct. 31, 1946
(month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: Wm. H. Downey

Address: 291 Frederick St., Hagerstown, Md.

19. Oct 28 19 46 E. Joyce Long
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 19 46 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 19 46, to Oct. 28 19 46

and that I last saw h... im ...alive on Oct. 28 19 46

Immediate cause of death: General Paresis — DURATION: known to us since 7/19/46

Due to: ---

Due to: ---

Other conditions: -------

(Include pregnancy within 3 months of death)

Major findings of operations: ---

---- Date of op. ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -------- Date of ----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ------ Injured at work?

23. SIGNATURE: Robert P. Winterode, M. D. or other

Address: Crownsville, Md. Date signed: Oct. 28

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09680

Reg. Diat. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred:
Route # 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Florida County:
City or town: West Palm Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. 205 Wenonah Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Philip Browne

3.(b) Social Security Number:

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6.(b) Name of husband or wife: Evelyn M. Browne
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 12, 1871

8. AGE: Years 75 | Months 6 | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace: Washington D. C.
(Town, county and state)

10. Usual occupation: Ret U.S.N.

11. Industry or business

FATHER
12. Name: Henry Browne
13. Birthplace: Maine

MOTHER
14. Maiden name: Harriet Naylor
15. Birthplace: Va

16. Informant: Mrs E. M. Browne
Address: 9505 Columbia Blvd. Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28 1946 (month) (day) (year)

Cemetery or crematory: Arlington
Location: Arlington Va

18. Funeral director: Warner E. Pumphrey
Address: Silver Springs Md.

19. Oct 28 1946 (Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1946 at 1 15 P. M

21. I CERTIFY that death occurred on the date above stated; ~~at the hour stated above~~
Postmortem Examination
~~at the place stated above~~ Oct. 23 1946

| Immediate cause of death | DURATION |
|---|---|
| Acute Dilatation of Heart | Sudden |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 10-23-46.


RECEIVED
OCT 96

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

## CERTIFICATE OF DEATH

09681

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 270 King Geo
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME** Cornelia R. Bryan

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W. | Widow |

6.(b) Name of husband or wife: Carryl H. Bryan
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 22d 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 1879 | 3 | 5 | hrs. min. |

9. Birthplace: Balto Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Thomas J. Boykin
13. Birthplace: Balto Md.

MOTHER — 14. Maiden name: Katharine W. Meeks
15. Birthplace: Portsmouth Va.

16. Informant: Henry V. Boykin
Address: 270 King Geo. St. Annapolis Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Oct 29 1946 (month) (day) (year)

Cemetery or crematory: Greenmount
Location: Baltimore Md.

18. Funeral director: John M Taylor Son
Address: Annapolis Md.

19. Oct 29 1946 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 27, 1946 at 5 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 24, 1946 to Oct. 27, 1946 and that I last saw h alive on Oct. 27, 1946

| Immediate cause of death | DURATION |
|---|---|
| Hemorrhage + Shock | 4 days |
| Due to Carcinoma of Cervix with metastasis to Pelvis | 3 yrs |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R Martin M.D.
M. D. or other
Address: 185 Pine George St Norfolk Date signed 10-28-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

09682

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Near St Margarets
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Near St Margarets
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Millard P. Cantler

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W. | Single |

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 19th 1856

8. AGE: Years 90 | Months 1 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Waterman & Hunter

11. Industry or business

FATHER
12. Name: David Cantler
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Susan Harwood
15. Birthplace: Harford Co Md.

16. Informant: Mrs Albert Cantler
Address: St Margarets A.A.Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 7th 1946 (month) (day) (year)

Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Gaylor Son
Address: Annapolis Md.

19. Oct 7, 1946 (Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5 1946 at 10 00 A.M.

21. I CERTIFY that death occurred on the date stated; that Post mortem Examination Oct. 5 1946

| | DURATION |
|---|---|
| Immediate cause of death: Acute Dilatation of Heart | sudden |
| Due to: General arterio-sclerosis | unknown |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Gaffy, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 10-7-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

08683

Reg. Dist. No. 28

**1. PLACE OF DEATH:**

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years, 11 mo., 2 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 30 yrs., 11 mo., 2 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3. (a) FULL NAME:** CARTER - EDMUND

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | single |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | | | hrs. min. |

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Stevedore

11. Industry or business:

FATHER 12. Name: unknown

13. Birthplace:

MOTHER 14. Maiden name: unknown

15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/11/46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt Hospital

Address: Crownsville

19. 10/11/46 (Date rec'd by registrar) E F Joyce Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 19 46 at 9:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29 19 15 to October 1 19 46 and that I last saw him alive on October 1 19 46

| Immediate cause of death | DURATION |
|---|---|
| General Arteriosclerosis | 10/29/15 |
| Due to: | |
| Due to: | |
| Other conditions: Schizophrenia Catatonic Type | 10/29/15 |

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op.:

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of:

Where did injury occur? ——— (City or town) ——— (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ——— Injured at work?

23. SIGNATURE: Albert J. Winkler M. D. or other

Address: Crownsville, Maryland Date signed: 10/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

★ 09684

Reg. Dist. No. 21

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 68 State Circle
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Isabella Howard Claude

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 12 1868

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 11 | 21 | hrs. min. |

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: Dr Abram Claude
13. Birthplace: Annapolis Md
MOTHER 14. Maiden name: Rachel Ann Tuck
15. Birthplace: Annapolis Md
16. Informant: Mrs Ann Claude
Address: Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 24 1946 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md
18. Funeral director: John M. Taylor Son
Address: Annapolis Md
19. Oct. 24 1946 (Date rec'd by registrar)
Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 22 1946, at 7 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1946, to Oct 22 1946
and that I last saw h[illegible] alive on Oct 22 1946

| Immediate cause of death | DURATION |
|---|---|
| Myocardial chy with Myocardial Insufficiency | Unknown |
| Due to | |
| | |
| Due to | |
| Other conditions Arteriosclerosis | Unknown |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Buck M. D. or other
Address: Annapolis Md Date signed: Oct 23 46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

## CERTIFICATE OF DEATH

★ 09685 Reg. Diat. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 42 Randall
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

**3. (a) FULL NAME:** Clarence M. Collins

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married. |

6.(b) Name of husband or wife: Pauline S. Collins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 13th 1920

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 26-8/12 | 3 | | ..... hrs. ..... min. |

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: Sheet Metal Worker
11. Industry or business:

FATHER
12. Name: J. Martin Collins
13. Birthplace: A A Co Md

MOTHER
14. Maiden name: Grace White
15. Birthplace: A A Co Md.

16. Informant: Mrs Grace Collins
Address: 185 Pi. Geo St Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 16th 1946 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. October 14 1946 (Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 13 1946 19 46, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 13 1946, to Oct 13 1946
and that I last saw him alive on Oct 13 1946

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | Few hrs |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo C Boeel M. D. or other
Address: Annapolis Md Date signed 10-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
OCT 15 1946
BUREAU V S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

## CERTIFICATE OF DEATH

★ 09686

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel Co
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 99 East Street
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 99 East Street
(If rural, give LOCATION)
****
2.(a) If veteran, name war

**3.(a) FULL NAME:** Mary T. Contee

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 1857

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 89 | 10 | | ..... hrs. ..... min. |

9. Birthplace: Annapolis Md. (Town, county, and state)

10. Usual occupation: Maid

11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: William J. Contee
Address: 99 East Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10- 26- 1946 (month) (day) (year)
Cemetery or crematory: St. Marys
Location: West Street

18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street

19. Oct 25 1946 (Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22nd 1946, at 7 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1946, to Oct 22 1946
and that I last saw h..er alive on Oct 21 1946

| | DURATION |
|---|---|
| Immediate cause of death: circulatory failure | |
| Due to: coronary disease | 2 yrs |
| Due to: arteriosclerosis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edith Roeller, M.D. M. D. or other
Address: 42 State Circle Annapolis Date signed: 10-25-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09687

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
County Anne Arundel
City or town Truxton Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? unknown
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town [redacted] Annapolis (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Truxton Heights
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William H. Cox

3.(b) Social Security Number 214-05-0334

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | single |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 1st 1905

8. AGE: Years 41 | Months 3 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis - A.A.Co. - Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name James H. Cox
13. Birthplace A.A. Co. Maryland

MOTHER
14. Maiden name Martha Evans
15. Birthplace A.A. Co. Maryland

16. Informant Mrs. Martha E. Cox
Address Weems Creek, A.A.Co. - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22nd 1946 (month) (day) (year)

Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18. Funeral director John M. Taylor & Son
Address Annapolis, Md.

19. Oct. 21 1946 (Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1946 at about 2.00 P.M.

21. I CERTIFY that death occurred on the date above stated: [redacted] Post mortem Examination [redacted] Oct. 18 1946.

| | DURATION |
|---|---|
| Immediate cause of death | |
| Due to Suicide by hanging | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide [redacted] Date of 10/18/46
Where did injury occur? Truxton Heights (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) vacant house
Means of injury hanged by neck Injured at work? No

23. SIGNATURE John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis, Md. Date signed 10/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

## CERTIFICATE OF DEATH

09688

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
74 Larkins Street
How long in hospital or institution? ******

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 74 Larkins
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mildred Sumner Curry

3. (b) Social Security Number: None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6.(b) Name of husband or wife: Edward Curry
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 20, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 2 | 6 | hrs. min. |

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None
FATHER 12. Name: Mills Sumner
13. Birthplace: Portsmouth Va.
MOTHER 14. Maiden name: Lucretia Appleby
15. Birthplace: Long Island N.Y.
16. Informant: Georgia Hyman
Address: 22 College Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-31-1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street
18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street
19. Oct. 30 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1946 at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1946 to Oct 26 1946 and that I last saw h[illegible] alive on Oct 25 1946

| Immediate cause of death | DURATION |
|---|---|
| Cerebral hemorrhage | |
| Due to Hypertension | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G. T. Allen M. D. or other
Address: 17 Carroll Pl. Date signed: 10-28-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09689

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo., 23 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 months, 23 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: ——— (If rural, give LOCATION)

2.(a) If veteran, name war: ———

**3.(a) FULL NAME:** FREEMAN - WALTER

**3.(b) Social Security Number:** ———

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | married |

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 48 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ———

FATHER — 12. Name: Ernest Freeman

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emma Jones

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 31 (month) (day) (year)

Cemetery or crematory: Mount Auburn

Location: Baltimore City, Maryland

18. Funeral director: I. L. Brown & Sons

Address: 108 W. Montgomery St., Balto, Md.

19. 10/30 (Date rec'd by registrar) 19 46 A. W. Hedrick Dr. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 19 46 at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 5 19 46 to Oct. 27 19 46

and that I last saw him alive on Oct. 27 19 46

Immediate cause of death: General Paresis — known to us since August 5, 1946 — DURATION

Due to:

Due to:

Other conditions: ———

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Hart J. Hinkerson M. D. or other

Address: Crownsville, Md. Date signed: Oct. 27

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

★ 09628 Reg. Dist. No. 28

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Riva
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Davidsonville Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

**3.(a) FULL NAME:** GARRETT - CORA

**3.(b) Social Security Number:** ———

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | BLACK | MARRIED |

6.(b) Name of husband or wife: ———
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years 65 | Months —— | Days —— | If less than one day ……hrs. ……min.

9. Birthplace: ——— (Town, county, and state)
10. Usual occupation: housework
11. Industry or business: ———

FATHER
12. Name: ———
13. Birthplace: ———

MOTHER
14. Maiden name: ———
15. Birthplace: ———

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 3, 1946 (month) (day) (year)
Cemetery or crematory: Mount Zion
Location: Mount Zion, Maryland

18. Funeral director: J. B. Johnson
Address: Annapolis, Maryland

19. Oct 31 1946 (Date rec'd by registrar) E. Jane Lowe Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 19 46 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 46 to October 30 19 46 and that I last saw her alive on October 30 19 46

| Immediate cause of death | DURATION |
|---|---|
| Cerebral arteriosclerosis known to us since May 1, 1946 | |
| Due to: | |
| Due to: | |
| Other conditions: Psychosis known since 5/1/46 (Include pregnancy within 3 months of death) | |

Major findings of operations: ———
Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Ward J. Braithwaite M. D. or other
Address: Crownsville, Maryland Date signed: Oct. 31

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

# CERTIFICATE OF DEATH

09691

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Ann Arundel Co.
City or town: Gambrills, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** John Richard Greenleaf

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6.(b) Name of husband or wife: Eliza Greenleaf
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb., I6, I889.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 7 | I6 | ..... hrs. ..... min. |

9. Birthplace: Gambrills, A.A. Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Henry Greenleaf
13. Birthplace: Md.
MOTHER 14. Maiden name: Martha Thomas.
15. Birthplace: Md.
16. Informant: Eliza Greenleaf
Address: Gambrills, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 6, I946. (month) (day) (year)
Cemetery or crematory: Mt. Tabot
Location: Chesterfield, Md.
18. Funeral director: J.B. Johnson.
Address: Annapolis, Md.
19. Oct 6 19 46 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 2, 19 46, at 9 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 46 to Oct. 2 19 46
and that I last saw h. alive on Oct 2, 19 46

| Immediate cause of death | DURATION |
|---|---|
| I Apoplexy | 1 wk |
| Due to Hypertension | 1 yr. |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J.W. Downey Jr. M. D. or other
Address: 60 Northern Ave. Date signed: 10/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 304

09692 8

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

**1. PLACE OF DEATH:**

County: Ann Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 3 months 3 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 year 3 months 3 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 222 Douglas Court Baltimore

(If rural, give LOCATION)

2.(a) If veteran, name war: Unknown

**3.(a) FULL NAME:** Andrew Jackson Hensen

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | married |

6.(b) Name of husband or wife: Mrs Etta Henson

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): ~~1844~~ 10. 12. ~~1896~~ 1891

**8. AGE:** Years: 55 Months: Days: If less than one day: hrs. min.

9. Birthplace: Georgia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Crownsville State Hospital

Address: Crownsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10-16-46 (month) (day) (year)

Cemetery or crematory: Arbutus Mem. Pk.

Location:

18. Funeral director: Joseph E. Lock, Jr.

Address: 1804 E. Centre Ave.

19. 10/14 1946 (Date rec'd by registrar) J. W. Redwell Registrar

I-35

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-12 1946, at 945 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-9 1945, to 10-12 1946 and that I last saw h... alive on 10-12 1946

| Immediate cause of death | DURATION |
|---|---|
| General Paresis | Known |
| Due to | to the |
| | onset |
| Due to | July 9 |
| | 1945 |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert V. Bintrock, M. D. or other

Address: Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

## CERTIFICATE OF DEATH

Reg. Dist. No. 09693 25

**1. PLACE OF DEATH:**
County 4104 Gov. Ritchie Highway
City or town Brooklyn Park Md a.a.Co
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County A. A. County
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4104 Gov. Ritchie Highway
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Halbert Wm Hoffman.

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife Emma V. Hoffman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 23 - 1880

8. AGE: Years 65 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Retired Fireman (R.R.
11. Industry or business B & O R.R.

FATHER
12. Name Halbert Hoffman
13. Birthplace Berks County Pa

MOTHER
14. Maiden name Elizabeth Swartz
15. Birthplace Maryland

16. Informant Mrs Emma V. Hoffman
Address 4104 Gov. Ritchie Highway

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 15-46 (month) (day) (year)
Cemetery or crematory Glen Haven Cemetery
Location Glenburnie

18. Funeral director Milton Schilling
Address 3914 Hanover St Balto 25 Md

19. Oct. 13 1946 Ida M. Whitaen Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1946, at 8:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1945, to October 1946 and that I last saw him alive on October 11 1946.

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Stomach | 1 yr. |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. J. Ponzaldi M.D.
M. D. or other
Address 4609 Gov. Ritchie Date signed 10-11-46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

Reg. Diat. No. 09694

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 2 months

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 years, 2 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 340 W. Biddle Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

**3.(a) FULL NAME:** JENKINS - MARY

**3.(b) Social Security Number:** ———

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | black | single |

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): ———

8. AGE: Years: 80 + | Months: — | Days: — | If less than one day: ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: ———

FATHER — 12. Name: Edward Jenkins

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rachel Cooper

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: Oct. 28, 1946 (month) (day) (year)

Cemetery or crematory: Easton Cemetery

Location: Easton, Maryland

18. Funeral director: Leon W. Henry

Address: 310 South Street, Easton, Maryland

19. 10/29/46 (Date rec'd by registrar) E.T. Joyce Lucas Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24, 1946, at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25, 1944 to October 24, 1946 and that I last saw her alive on October 24, 1946

| Immediate cause of death | DURATION |
|---|---|
| General Arteriosclerosis known to us since 8/25/44 | |
| Due to | |
| Due to | |
| Other conditions: Senile Psychosis known to us since 8/25/44 (Include pregnancy within 3 months of death) | |

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Herbert J. Hinderer, M. D. or other

Address: Crownsville, Maryland Date signed: Oct. 25

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

09696 D

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: A. A. Co.
City or town: Clear Water Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Clear Water Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Rosa M. Jenkins

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | M. |

6.(b) Name of husband or wife: Howard P. Jenkins
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 27 1882

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 8 | 3 | hrs. min. |

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Henry Goodrich
13. Birthplace
MOTHER 14. Maiden name: Elizabeth Hamilton
15. Birthplace
16. Informant: Howard P. Jenkins
Address: Greenland Beach
17. Burial (Burial, cremation, or removal? Which?) Date thereof: 11-7-1946 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: A. A. Co. Md.
18. Funeral director: Flynn & Fleming
Address: 1476 Light St.
19. 11/4/46 (Date rec'd by Registrar) A. W. Hedrick Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct 30" 1946, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946, to Oct 30 1946
and that I last saw her alive on Oct 29 1946

| Immediate cause of death | DURATION |
|---|---|
| Ex haemorrhage | 3 days |
| Due to: Cerebral Hemorrhage | 2½ Wks. |
| Due to: | |
| Other conditions: None | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. E. Campbell M. D. or other
Address: 1644 Hanover Date signed: Nov 1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

★ 09695

Reg. Dist. No. 28

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs., 10 mo., 24 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 17 years 10 mo, 24 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: ———
(If outside city or town limits, write RURAL and give nearest town)
Street No. ———
(If rural, give LOCATION)
2.(a) If veteran, name war ———

**3.(a) FULL NAME:** JENKINS - TINA

**3.(b) Social Security Number:** ———

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | black | married |

6.(b) Name of husband or wife: ———
6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.): ———

8. AGE: Years 76 ? | Months — | Days — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ———

FATHER
12. Name: William Mister
13. Birthplace: Maryland

MOTHER
14. Maiden name: Catherine Travers
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Cambridge Md.

18. Funeral director: Lewis & Henry, Cambridge Md.
Address

19. Oct 26, 1946 (Date rec'd by registrar) E. Joyce Lowe Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1946, at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 1928, to Odtober 23 1946
and that I last saw her alive on October 23 1946

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | known to us since |
| | August, 1946 |
| Due to: | |
| Due to: | |
| Other conditions: Senile Psychosis | known to us since 12/1/28 |

(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Harry J. Hinderodt M. D. or other
Address: Crownsville, Maryland Date signed: Oct. 25, '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09697

Reg. Diat. No. 28

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yr. 3 mo. 8 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 yr. 3 mo. 8 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Center St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

**3.(a) FULL NAME:** JEWS - MARGARET E.

**3.(b) Social Security Number:** ---

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | black | single |

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): ---

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | - | - | ---hrs. ---min. |

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: ---
11. Industry or business: ---

FATHER
12. Name: ---
13. Birthplace: ---

MOTHER
14. Maiden name: ---
15. Birthplace: ---

16. Informant: Hospital Records
Address: Crownsville, State Hospital

17. Buried (Burial, cremation, or removal. Which?) Date thereof 10/10/46 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Cambridge, Maryland

18. Funeral director: Louis H. Rayneum
Address: Cambridge, Maryland

19. 10/16 46 (Date rec'd by registrar) 19.... E. J. Joyce Beal Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6, 1946, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1946 to October 6 1946 and that I last saw her alive on October 6 1946

| Immediate cause of death | DURATION |
|---|---|
| Lung Tuberculosis | known to us since 6/18/46 |
| Due to: | |
| Due to: | |
| Other conditions: Schizophrenia simple type known to us since 1940 | |

(Include pregnancy within 3 months of death)

Major findings of operations: ***** ---
Date of op. ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of ---
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Albert J. Phiebig M. D. or other
Address: Crownsville, Maryland Date signed: Oct. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

## CERTIFICATE OF DEATH

Bal 09698

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo., 7 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 8 mo., 7 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 525 Presstman Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3. (a) FULL NAME:** JOHNSON - ROSE

**3. (b) Social Security Number:** unknown

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | black | widow |

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | | | hrs. min. |

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Isaac Guilbert

13. Birthplace: Georgia

MOTHER — 14. Maiden name: Fanny Rosemary Lewis

15. Birthplace: Georgia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5. 46 (month) (day) (year)

Cemetery or crematory: Mt Auburn.

Location: Baltimore City.

18. Funeral director: Geo. B. Kelbon

Address: 1305 Presstman. St.

19. Oct 3 (Date rec'd by registrar) 1946 Mae Alba Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1946 at 7:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25 1946 to October 1 1946

and that I last saw her alive on October 1 1946

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | known to us since 1/25/46 |
| Due to: | |
| Due to: | |
| Other conditions: Senile Psychosis - Simple Deterioration | known to us since 1/25/46 |

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ———

Accident, suicide, or homicide: Date of ———

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury: Injured at work?

23. SIGNATURE: Albert J. Winkler M. D. or other

Address: Crownsville, Maryland Date signed 10/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

05055
69697

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 Years
Hospital, institution, or street address where death occurred: 17 Clay Street
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 17 Clay Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Sarah Johnson

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6.(b) Name of husband or wife: John H. Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 15, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 0 | 3 | hrs. min. |

9. Birthplace: Rutland Md. A. A. Co.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mary Johnson Colbert
Address: 17 Clay Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10- 22- 1946 (month) (day) (year)
Cemetery or crematory: Mt. Tabor
Location: Chesterfield Md.

18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street

19. Oct. 22 1946 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct 18 1946, at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17 1946, to Oct 18 1946, and that I last saw her alive on Oct 18 1946

| | DURATION |
|---|---|
| Immediate cause of death: Chr. Myocarditis c decompensation | 2 mos |
| Due to: Acute Insufficiency | yrs. |
| Due to: | |
| Other conditions: Gangrene of L. foot | 2 wks. |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M. F. Kleware, MD M. D. or other
Address: 31 South Gay St Date signed: 10/21/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

09700

## CERTIFICATE OF DEATH

Reg. Diat. No. 28

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 26 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1426 Argyle Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ----

**3. (a) FULL NAME:** KELLY - BENJAMIN

**3. (b) Social Security Number:** ----

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | widow |

6.(b) Name of husband or wife: ***----

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1876 ?

8. AGE: Years: 70 Plus | Months: | Days: -- | If less than one day: ....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ----

FATHER
12. Name: Ben Kelly
13. Birthplace: Maryland

MOTHER
14. Maiden name: Celenta Butler
15. Birthplace: ----

16. Informant: Hospital Records
Address: Crownsville State Hospital

17. buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 2, 1946 (month) (day) (year)

Cemetery or crematory: St. Johns

Location: Hollywood, Maryland

18. Funeral director: P. B. Robinson

Address: Leonardtown, Maryland

19. 11-1 (Date rec'd by registrar) 19 46 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 30 19 46 at 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4 19 46 to October 30 19 46 and that I last saw him alive on October 30 19 46

| Immediate cause of death | DURATION |
|---|---|
| General Arteriosclerosis known to us since 10/4/46 | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.: ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: ---- Injured at work? ----

23. SIGNATURE: Herbert J. Pinderhughes M. D. or other

Address: Crownsville, Maryland Date signed: Oct. 30 1946

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-A)

## CERTIFICATE OF DEATH

09701

Reg. Dist. No. 23

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Shipley Heights, Linthicum P.O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Shipley Hghts ( Linthicum, Md.)
(If outside city or town limits, write RURAL and give nearest town)

Street No. 416 Shipley Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** NANETTE LAMBERT

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: William H. Lambert

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): January 18, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 9 | 1 | ...hrs. ...min. |

9. Birthplace: Wayne, N.J. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: OWN HOME

FATHER
12. Name: Edward J. Mayden
13. Birthplace: England

MOTHER
14. Maiden name: Emma Talmadge
15. Birthplace: Dover, N.J.

16. Informant: Mr. William H. Lambert
Address: 416 Shipley Road, Linthicum, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 22, 1946 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Oct 21 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19, 1946, at 8.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/19/46 19... to 10/19/46 19...

and that I last saw her alive on 10/19/46 19...

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | 7 hrs. |
| Due to: Broken left humerus | 2 weeks |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 2 weeks ago

Where did injury occur? Shipley Heights (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fell down the stairway Injured at work? No

23. SIGNATURE: Gustave A. Pauleduro M.D. M. D. or other

Address: Glen Burnie, Md. Date signed: 10/20/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 09702 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

**1. PLACE OF DEATH:**
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred Emergency Hospital
How long in hospital or institution

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 N. Woodlawn Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Raymond M. Lauer

**3.(b) Social Security Number**

| 4. Sex | 5. Color or Race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife Alverda Burrell Lauer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 2nd 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 11 | 16 | ..... hrs. ..... min. |

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual occupation Clerk Md. State Income Tax Office
11. Industry or business
FATHER 12. Name Jos. W. Lauer
13. Birthplace Maryland
MOTHER 14. Maiden name Louisa Haig
15. Birthplace Maryland
16. Informant Mrs Raymond M. Lauer
Address 107 N. Woodlawn Ave Annapolis Md.
17. Burial Date thereof Oct 24th 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Layton Son
Address Annapolis Md.
19. Oct. 21 1946 [illegible] Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct 18 1946, at 5 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Oct 18 1946
and that I last saw him alive on Oct 18 1946

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | Sudden |
| Due to Arteriosclerosis & Mild | unk |
| Due to | |
| | 6 years |
| Other conditions Hypertension | 6 years |
| Myocarditis (chr) | |

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE George C Boarl
M. D. or other
Address Annapolis Md Date signed 10-19-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

BV 09704 B

Reg. Dist. No. 28

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 11 mo. 24 da.
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 yrs., 11 mo., 24 da.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2013 Madison Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

**3.(a) FULL NAME:** MARROW - NELLIE

**3.(b) Social Security Number:** unknown

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | black | single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1920

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 26 | | | hrs. min. |

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:
FATHER 12. Name: William Marrow
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Rosie Fields (dead)
15. Birthplace: North Carolina
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 5, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Baltimore, Md.
18. Funeral director: Mrs. Geo. A. Hallam
Address: 601 Druid Hill Ave.
19. 10-5-46 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2 1946 at 5:00a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7, 1942 to Oct. 2 1946
and that I last saw her alive on October 1 1946

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Tuberculosis | known to us since 9/4/46 |
| Due to | |
| Due to | |
| Other conditions: Schizophrenia - Paranoid Type (Include pregnancy within 3 months of death) | known to us since 10/7/42 |

****

Major findings of operations: ———— Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ———— Date of
Where did injury occur? ———— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert V. Strickler M. D. or other
Address: Crownsville, Maryland Date signed: 10/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

09705

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1252 Battery Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

**3. (a) FULL NAME:** Margaret C. McDonald

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W. | Married |

6.(b) Name of husband or wife: James E. McDonald
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 2-10-1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 8 | 17 | hrs. min. |

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: House
11. Industry or business:
FATHER 12. Name: John Connolly
13. Birthplace: Ireland
MOTHER 14. Maiden name: Catherine Concannon
15. Birthplace: Ireland
16. Informant: James E. McDonald
Address: 1252 Battery Ave Balto. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-31-46 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Baltimore Md.
18. Funeral director: John J. Fahey & Sons
Address: 1318 Light St. Balto. Md.
19. Oct 27 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1946, at 5.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1946, to Oct 27 1946
and that I last saw h.. alive on Oct. 27 1946

| Immediate cause of death | DURATION |
|---|---|
| Uraemia | 3 Wks |
| Due to: General Cardio-Vasc. Renal Failure | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Maurice J. Klaveras, Md
M. D. or other
Address: 31 South Gate Ave Date signed: 10/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-G)

## CERTIFICATE OF DEATH

Reg. Diat. No. 09706 20

**1. PLACE OF DEATH:**

County A. A.

City or town Woodland Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, Institution, or street address where death occurred:
Woodland Beach

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County A. A.

City or town Woodland Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No. Edgewater Post Office
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Frances May McKenzie

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife Edward L McKenzie

6.(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) April 9, 1925

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 21 | 5 | 27 | ....hrs. ....min. |

9. Birthplace Mitchellville, Prince George County
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Franklin Beall
13. Birthplace Maryland

MOTHER
14. Maiden name Martha Daisy Tayman
15. Birthplace Maryland

16. Informant

Address Woodland Beach, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 8, 1946 (month) (day) (year)

Cemetery or crematory Mount Carmel Cemetery

Location Upper Marlboro, Maryland

18. Funeral director B. L. Hopping & Son

Address 170 West St., Annapolis, Md.

19. Oct. 7, 1946 (Date rec'd by registrar) Edw. Collemore Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1946 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination

Oct. 5 1946

| Immediate cause of death | DURATION |
|---|---|
| Acute Dilatation of Heart | sudden |
| Due to Chronic Rheumatic Cardiac disease | unknown |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John M. Claffy, M.D. Deputy Medical Examiner
M. D. or other

Address Annapolis, Md. Date signed 10/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-6)

## CERTIFICATE OF DEATH

09707

Reg. Diat. No. 28

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 27 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

Street No. ———
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** MILLER - JOE

**3.(b) Social Security Number:** ———

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | married |

6.(b) Name of husband or wife: Flossy Miller ?

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 43 | Months: — | Days: — | If less than one day: ... hrs. ... min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: unknown

13. Birthplace:

MOTHER — 14. Maiden name: unknown

15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/19/46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt.

Address: Crownsville Md

19. 10/19/46 (Date rec'd by registrar) E. F. Joyce Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 8 19 46 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 11 19 46, to October 8 19 46 and that I last saw him alive on October 8 19 46

| Immediate cause of death | DURATION |
|---|---|
| general paresis | known to us since 9/11 1946 |
| Due to | |
| Due to | |
| Other conditions: ——— | |

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ...

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Owen V. Brookes M. D. or other

Address: Crwonsville, Md. Date signed: Oct. 9, '46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176-C)

## CERTIFICATE OF DEATH

09708

Reg. Dist. No. 23

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Bell-Grove Road (near Brooklyn Pk)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? None (Auto Accident)

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 130 Edgevale Road
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

**3.(a) FULL NAME:** William Robert Mitchell, Jr.

**3.(b) Social Security Number:** 219-12-7972

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 24, 1924

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 11 | 11 | ..... hrs. ..... min. |

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: American Oil Co. Balto. Md.

FATHER
12. Name: William Robert Mitchell, Sr.
13. Birthplace: Harlan, Ky.

MOTHER
14. Maiden name: Carrie S. Bready
15. Birthplace: London, Ky.

16. Informant: Mrs. Carrie S. Mitchell
Address: 130 Edgevale Road, Brooklyn Pk. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 16, 1946 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Cedar Hill, Brooklyn, Md. R.F.D.

18. Funeral director: Thomas W. Dunleton

Address: Glen Burnie, Md.

19. Oct 15 19 46 (Date rec'd by registrar) M. Deal Alba Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 13 1946, at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | Instant |
| Due to: Fracture of left Parietal and left temporal | |
| Due to: Automobile Accident | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10/13/46

Where did injury occur? Brooklyn Park (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Road.

Means of injury: Automobile Accident Injured at work? NO

23. SIGNATURE: Gustad H. Faulenbach M.D.
attending Physician M. D. or other

Address: Glen Burnie, Md. Date signed: 10/14/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

# CERTIFICATE OF DEATH

09709 8

Reg. Dist. No. 25 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Anne Arundel
City or town Curtis Bay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County AA Co
City or town Curtis Bay
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2704 Bungalow Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Milton LeRoy Moore Sr.

**3.(b) Social Security Number** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife Violet Johnson Moore
6.(c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) January 21, 1899
8. AGE: Years 47 Months Days If less than one day hrs. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name John F Moore
13. Birthplace Md
MOTHER 14. Maiden name Sarah Sharp
15. Birthplace Md
16. Informant Mrs Violet Moore Sr
Address 2704 Bungalow Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/46 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Annapolis Blvd
18. Funeral director John F Denny Inc
Address 75 Light St
19. 10/14 (Date rec'd by registrar) 19 46 F. W. Hedrick Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH October 12th 19 46, at 8:30 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20 19 44, to Oct. 10 19 46
and that I last saw h. alive on Oct. 10 19 46

| Immediate cause of death | DURATION |
|---|---|
| Hypertension | 2 years |
| cardio vascular disease | 8 mo. |
| Due to — | |
| Due to — | |
| Other conditions — | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry Deibel M. D. or other
Address 1226 Hanover St. Date signed 10/10/46

10455

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: District Tr. School, Laurel, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mo. 27 days
Hospital, Institution, or street address where death occurred:
District Training School
How long in hospital or institution? Laurel, Md

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.: District Tr. School
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** James Patterson (Montague)

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | single |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 4, 1944

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 2 | 2 | 22 | hrs. min. |

9. Birthplace: Gallinger Mu. Hos. Washington DC
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: (Putative) Wesley Montague
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary Etelen (Patterson)
15. Birthplace: Washington, D.C.

16. Informant: Records of Dist. Tr. School
Address: Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 29-46 (month) (day) (year)
Cemetery or crematory: Dist Tr School
Location: near Laurel Md

18. Funeral director: Funerals of Dist Tr School
Address: Laurel Md

19. Oct 28 1946 (Date rec'd by registrar) Clara Haslup Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 26 1946, at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 1946, to Oct. 26 1946
and that I last saw him alive on October 26 1946

| Immediate cause of death | DURATION |
|---|---|
| Immediate: Pneumonia | 3 mo. |
| Due to: Edema, Birth Injury | Life |
| Due to: | |
| Other conditions: Convulsive Seizures | Life |
| Spastic Paraplegia | " |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James L. Wood M.D. (M. D. or other)
Address: District Tr. School Date signed: 10/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09710

## CERTIFICATE OF DEATH

Reg. Diat. No. 25

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. and 23 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 year and 23 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. ----
(If rural, give LOCATION)

2.(a) If veteran, name war: ----

**3. (a) FULL NAME:** PINDER - GEORGE

**3. (b) Social Security Number:** ----

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | married |

6.(b) Name of husband or wife: **----------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): 1914

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | | | ....hrs. ....min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: ----

FATHER
12. Name: Henry Pinder
13. Birthplace: Maryland

MOTHER
14. Maiden name: Pearl Lee
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried
(Burial, cremation, or removal. Which?)
Date thereof: Oct. 31, 1946
(month) (day) (year)

Cemetery or crematory: Mount Calvary

Location: Baltimore, Maryland

18. Funeral director: I. L. Brown & Sons

Address: 108 Montgomery St., Balto., Md.

19. 10/30 19 46 A. W. Hedrick
(Date rec'd by registrar) Registrar

1-25

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 19 46 at 3:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5 19 45 to Oct. 27 19 46 and that I last saw him alive on October 27 19 46

Immediate cause of death: General Paresis — DURATION: Known to us since Oct. 5, 1945

Due to:

Due to:

Other conditions: ----

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.:

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

Where did injury occur? ----
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----

Means of injury: ---- Injured at work? ----

23. SIGNATURE: Howard A. Kirkbride
M. D. or other

Address: Crownsville, Maryland Date signed: Oct. 27, 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (d)

## CERTIFICATE OF DEATH

★ 09711

Reg. Dist. No. 2a

**1. PLACE OF DEATH:**

County aa

City or town Friendship

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County aa

City or town Friendship

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Josie J. Bruyer

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6.(b) Name of husband or wife J. J. Bruyer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | | | ..... hrs. ..... min. |

9. Birthplace W. Va (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name W. J. Jones

13. Birthplace W. Va

MOTHER 14. Maiden name Mary Jones

15. Birthplace

16. Informant Miss Lou Jones

Address Friendship Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9 46 (month) (day) (year)

Cemetery or crematory Cemetery

Location Bridgewater, Va

18. Funeral director W. H. Hutchison

Address Owings, Md

19. Oct 8 1946 (Date rec'd by registrar) Grace L. Hutchison Registrar

Ed. Collinson

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 10/7 1946 at 10 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to Oct 7 1940 and that I last saw h[illegible] alive on Oct 7 1940

| | DURATION |
|---|---|
| Immediate cause of death Cerebral accident | 4 days |
| Due to Diabetes Mellitus | 15 yrs |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Bond M. D. or other

Address Owings Md Date signed 10/12/46

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09712

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or institution? 12 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 934 Broward St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** Sylvester Robinson

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Married |

6.(b) Name of husband or wife: Mary Robinson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 10 1890

8. AGE: Years: 70 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: N. C. (Town, county, and state)
10. Usual occupation: Porter
11. Industry or business:
12. Name of FATHER: Thomas Robinson
13. Birthplace of FATHER: N. C.
14. Maiden name of MOTHER: N. Owens
15. Birthplace of MOTHER: N. C.
16. Informant: Winston Robinson
Address: 934 Broward St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 28-46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City
18. Funeral director: Thomas E. Robinson
Address: 1303 Presstman St.
19. Oct 25 1946 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct. 23, 1946, at 11 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 11 1946 to Oct. 23 1946 and that I last saw him alive on Oct. 23 1946

| Immediate cause of death | DURATION |
|---|---|
| General Debility, | unknown |
| Due to: Hypostatic Pneumonia | 1 week |
| Due to: Chronic myocarditis | unknown |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D.
M. D. or other
Address: Annapolis Maryland Date signed: 10-23-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-6)

## CERTIFICATE OF DEATH

09713p

Reg. Dist. No. 22

**1. PLACE OF DEATH:**
County A. A. Co.
City or town Jessups Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Hill Top School - 5 mos.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Balto. Co.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 613 Dumbish Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Laurence Edward Ryan

**3.(b) Social Security Number** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | — |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1935

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 11 | 1 | 2 | ..... hrs. ..... min. |

9. Birthplace Owensboro Ky.
(Town, county, and state)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name Edward W. Ryan
13. Birthplace Watford England

MOTHER
14. Maiden name Mildred Ritter
15. Birthplace Chinfield Ill.

16. Informant Mrs Moore
Address Hill Top School Jessups Md.
17. Burial Date thereof Oct 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Woodland
Location Quincy, Ill.
18. Funeral director S. Lester Earp
Address 5503 Main St. Elkridge, Md.
19. 10/12 19 46 [illegible] Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11th 1946 at 12.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/10/46 19.. to 10/11/46 19..
and that I last saw h.. alive on 10/11/46 19..

| Immediate cause of death | DURATION |
|---|---|
| Rheumatic Heart Disease | ? |
| Due to | |
| Due to | |
| Other conditions Decompensation | 12 hrs. |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE Frank Shipley M.D.
M. D. or other
Address Savage, Md. Date signed 10/11/46

M

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

not BC. 09714 C.

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

**1. PLACE OF DEATH:**

County Anne Arundel

City or town Rural - Woodland Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1224 E. North Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Edward Alphonse St. Jean

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

B.(b) Name of husband or wife Mrs. Lillian Pearl St. Jean

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1895

8. AGE: Years 51 Months 1 Days 12 If less than one day ..... hrs. ..... min.

9. Birthplace Lynn, Mass.
(Town, county, and state)

10. Usual occupation Manager

11. Industry or business Yacht Club

FATHER 12. Name Edward Alphonse St. Jean

13. Birthplace Boston, Mass.

MOTHER 14. Maiden name Ada Monteure

15. Birthplace Boston, Mass.

18. Informant Wife

Address Woodland Beach

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof OCT. 12, 1946 (month) (day) (year)

Cemetery or crematory WOODLAWN

Location WOODLAWN, MARYLAND

18. Funeral director WILLIAM COOK, INC

Address 1217 ST. PAUL ST.

19. 10-10-46 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1946 at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..... to ..... 19.....

~~and that I last saw h~~ alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Cardiorespiratory failure | |
| Due to coronary Thrombosis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward P. Ritchings, M.D.
M. D. or other

Address 199 Gloucester St. Annapolis, Md. Date signed Oct. 9, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

I-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

09715

## CERTIFICATE OF DEATH

Reg. Dist. No. 58

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 11 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: East New Market
(If outside city or town limits, write RURAL and give nearest town)

Street No. ———
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

**3. (a) FULL NAME:** SAMPSON - ROBERT

**3. (b) Social Security Number:** ———

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | widow |

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): unknown

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| elderly | ? | ? | ...hrs. ...min. |

9. Birthplace: ———
(Town, county, and state)

10. Usual occupation: ———

11. Industry or business: ———

FATHER 12. Name: ———

FATHER 13. Birthplace: ———

MOTHER 14. Maiden name: ———

MOTHER 15. Birthplace: ———

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct. 29, 1946 (month) (day) (year)

Cemetery or crematory: Washington Cemetery

Location: Hurlock, Maryland

18. Funeral director: J. J. Frampton

Address: Federalsburg, Maryland

19. 10 26 19 46 (Date rec'd by registrar) E. Joyce Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 19 46 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 19 46, to October 25 19 46 and that I last saw him alive on October 25 19 46

Immediate cause of death: general arteriosclerosis — DURATION: known to us since Oct. 11, 1946

Due to: ———

Due to: ———

Other conditions: ———

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ———

Means of injury: ——— Injured at work? ———

23. SIGNATURE: Hart L. Bintzrode, M. D., or other

Address: Crownsville, Maryland Date signed: Oct. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

## CERTIFICATE OF DEATH

09716

Reg. Dist. No. 23

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Shipley Hghts. Linthicum, Md. P.O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Shipley ( Linthicum, Md. P.O. )
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 510 Shipley Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** MINNIE A. SEARS

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Eldridge F. Sears

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 19, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 4 | 16 | ...hrs. ...min. |

9. Birthplace: Dickson City, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Benjamin Hall

13. Birthplace: England

MOTHER — 14. Maiden name: Anna Schaeffer

15. Birthplace: Dickson City Pa.

16. Informant: Eldridge F. Sears

Address: Shipley Linthicum Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10, 1946. (month) (day) (year)

Cemetery or crematory: Mount Zion

Location: Anne Arundel County, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. October 8 1946 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: October 5, 1946, at 10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 10 1946, to Oct. 5 1946, and that I last saw h.. alive on Oct. 5 1946

| Immediate cause of death | DURATION |
|---|---|
| Cardiac Decompensation | |
| Due to Hypertensive Cardio-Vascular | |
| Renal Disease | |
| Due to Arterio-Sclerosis | |
| Other conditions Hemaplegia - | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Lubin M.D. M. D. or other

Address: 320 Putnam Ave Date signed: 10/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09717

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County Anne Arundel
City or town Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Army Area Regional Station Hospital, Ft. Geo. G. Meade, Md.
How long in hospital or institution? About 4½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
FRED SHELBY

3.(b) Social Security Number

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | |

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6 1881

8. AGE: Years 65 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name
FATHER 13. Birthplace
MOTHER 14. Maiden name
MOTHER 15. Birthplace
16. Informant
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27, 1946 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis, Md.
18. Funeral director J. B. Johnson
Address Annapolis, Md.
19. 7 October 1946 (Date rec'd by registrar) BERNARD F. KERWIN, Capt., Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1946, at 5 25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 PM Oct. 6, 1946 to 5 25 AM Oct. 6 1946 and that I last saw him alive on October 6, 1946

| Immediate cause of death | DURATION |
|---|---|
| Sub-dural hemorrhage | |
| Due to injuries received when patient was struck by auto on Annapolis Rd. near Fort Meade, Md. about 1:27 PM 5 Oct. '46 | |
| Due to fractures of right tibia & fibula, fractures of nose & left femur; lacerations of scalp. | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations 8 black silk sutures each inserted into 2 eight inch lacerations under sterile precautions Date of op. 6 Oct. 1946
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 5 Oct. '46
Where did injury occur? Annapolis Rd. near Fort Meade, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public highway
Means of injury Automobile Injured at work? No

23. SIGNATURE James F. Jackson Capt. MC M. D.
Address Regional Hospital, Ft. Meade, Md. Date signed 14 Oct. '46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PC

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

2

★ 09718 21 Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 110 Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Bradford Simms

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Divorced |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 12, 1898

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 48 | 2 | 18 | ..... hrs. ..... min. |

9. Birthplace: A Annapolis, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: William H. Simms

13. Birthplace: A.A.Co.

MOTHER 14. Maiden name: Alice Brown

15. Birthplace: Md.

16. Informant: Duglas Simms

Address: 1910 Clay St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 3, 1946 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis, Md.

19. Nov. 2, 1946 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 31 1946, at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Oct 30 1946 and that I last saw h[illegible] alive on Oct 30 1946

Immediate cause of death: Carcinoma of Stomach — DURATION: 3 months

Due to:

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

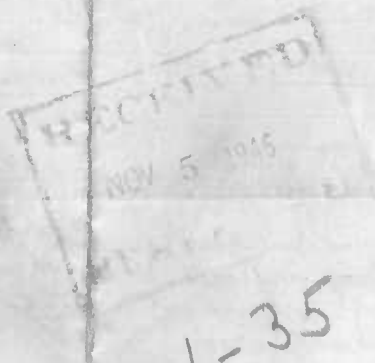
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. J. Richardson M.D. M. D. or other

Address: Annapolis Md. Date signed: 11/2/46.




1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09719

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
48 College Creek Terrace
How long in hospital or institution? ***********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 48 College Creek Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: **********

3.(a) FULL NAME: Mary Elizabeth Si mms

3.(b) Social Security Number: None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Single |

6.(b) Name of husband or wife: **********
6.(c) If alive, give age: *** years

7. Birth date of deceased (mo., day, yr.): April 15, ~~1946~~ 1931

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 15 | 5 | 29 | ....hrs. ....min. |

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)
10. Usual occupation: School Girl
11. Industry or business: None

FATHER
12. Name: Louis Simms
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Mildred Reed
15. Birthplace: Baltimore Md.

16. Informant: Mrs Elizabeth Simms
Address: 48 College Creek Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10/13/46 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West Street Extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest st. Annapolis Md.

19. Oct. 11 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-6 1946 at 12 05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-18 1946, to 10-6 1946
and that I last saw h... alive on 10-5-46 1946

Immediate cause of death: Pulmonary tuberculosis — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. T. Abbott M.D. M. D. or other

Address: 17 Carroll St Date signed: 10-11-46

VS A15 9-45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

09720

Reg. Dist. No. 21 0

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Skidmore near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital or Institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 3 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Skidmore Md Near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Skidmore Near Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Louise Smith

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Widowed |

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 4 | 12 | hrs. min. |

9. Birthplace: Taylorsville (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business: None
FATHER 12. Name: Henry Greene
13. Birthplace: Unknown
MOTHER 14. Maiden name: Hester Snowden
15. Birthplace: Unknown
16. Informant: Nanie Thomas
Address: 104 Clay St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11- 3- 1946 (month) (day) (year)
Cemetery or crematory: Broad Neck
Location: Skidmore Md
18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street
19. Nov 2, 1946 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 30 Oct 1946, at 8 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Oct 1946, to 30 Oct 1946, and that I last saw h-- alive on 30 Oct 46 19..

| Immediate cause of death | DURATION |
|---|---|
| Bronchopneumonia | 3 days |
| Due to Organism not determined | |
| Due to | |
| Diher conditions Pyelitis acute | 8 days |
| Hypertrophic arthritis, severe, Left Knee (Include pregnancy within 3 months of death) | + 2 years. |

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Donald H. Hunter, M.D. M. D. or other
Address 53 Cornhill St. Annapolis, Md. Date signed 1 Nov 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15


1-35

Evidence for the change of age and birthdate is shown on 2

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5-6)

## CERTIFICATE OF DEATH

★ 09721

Reg. Diat. No. 210

FILED No. 108 DEC 2, 1946

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 Years
Hospital, Institution, or street address where death occurred: 14 Obrine Court
How long in hospital or Institution? -----

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 14 Obrine Court
(If rural, give LOCATION)
2.(a) If veteran, name war: --------

**3.(a) FULL NAME:** James Henry Snowden

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6.(b) Name of husband or wife: Jane Snowden
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 10, 1881 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 65 | 0 | 19 | ..... hrs. ..... min. |

9. Birthplace: Prince George County Md.
(Town, county, and state)
10. Usual occupation: General Utility
11. Industry or business: None

FATHER
12. Name: Henry Snowden
13. Birthplace: Prince George County Md.

MOTHER
14. Maiden name: Mary Giles
15. Birthplace: Prince George County Md.

16. Informant: Jane Snowden
Address: 14 Obrine Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11- 3- 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street
18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street

19. Nov 2, 1946 (Date rec'd by registrar) ..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 29 19 46, at 5 45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 19 45, to Oct 29 19 46
and that I last saw h... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of Prostate | 2 yrs |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. H. Johnson M. D.
M. D. or other
Address 40 Northwest St. Date signed .....

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

09722

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

VS A15 9-45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Harry L. Spriggs

**3.(b) Social Security Number:**

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Jessie M. Spriggs
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept 5th 1877

8. AGE: Years: 69 Months: 1 Days: 7 If less than one day: ... hrs. ... min.

9. Birthplace: A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Edward Spriggs
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Mary F. Hoyd.
15. Birthplace: A. A. Co. Md.

16. Informant: Mrs Francis Engel
Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 14th 1946 (month) (day) (year)

Cemetery or crematory: Asbury
Location: Arnold, Md.

18. Funeral director: John H. Taylor & Son
Address: Annapolis Md.

19. October 14 1946 (Date rec'd by registrar)
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-12- 1946, at 1 25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-10- 1946, to 10-12- 1946
and that I last saw h... alive on 10-12- 1946

| | DURATION |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | 2 days |
| Due to: Hypertensive Cardio-Vascular Disease | 1 yr. |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: James R. Martin, Jr. M.D.
M. D. or other
Address: 186 Prince George St, Annapolis, Md. Date signed: 10-12-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

09723 Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County A. A. c
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County A. A.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Alfred Williams

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | married |

6.(b) Name of husband or wife Hattie Williams
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Oct. 1946

8. AGE: Years 70 yrs. Months Days If less than one day hrs. min.

8. Birthplace Waterboro, S.C.
(Town, county, and state)

10. Usual occupation U.S.N.A. Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant Hattie Williams
Address R.F.D. 2 Box 335 Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 30 1946 (month) (day) (year)
Cemetery or crematory Broadneck
Location St. Margarets

18. Funeral director J. B. Tomasso
Address Annapolis

19. Oct 28 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1946 at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1945, to Oct 27 1946
and that I last saw h alive on 1946

Immediate cause of death Cardiac Failure — DURATION

Due to Hypertension cardio Vascular

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. H. Johnson M.D.
M. D. or other
Address 40 N. Gilmor St. Date signed 10/28/46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

## CERTIFICATE OF DEATH

09724

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Galesville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life 44 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Galesville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

**3. (a) FULL NAME:** Albert Wilbur Woodfield

**3. (b) Social Security Number:** none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Louise Marguerite
6.(c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): Sept 15 1902
8. AGE: Years: 44 Months: 0 Days: 21 If less than one day: hrs. min.
9. Birthplace: Galesville A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Oyster Packer
11. Industry or business: Fish dealer
FATHER 12. Name: Herman Woodfield
FATHER 13. Birthplace: Galesville, Md.
MOTHER 14. Maiden name: Bessie Sears
MOTHER 15. Birthplace: Harwood, Md.
18. Informant: Louise M. Woodfield
Address: Galesville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 9 1946 (month) (day) (year)
Cemetery or crematory: Woodfields
Location: Galesville Md.
18. Funeral director: E. E. Stanley & Son
Address: Galesville Md.
19. Oct 8 1946 (Date rec'd by registrar) W. N. Clayton Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above etated; that I attended deceased from Oct 6 1946 to Oct 6 1946 and that I last saw h... alive on Not at all. 1B

| Immediate cause of death | DURATION |
|---|---|
| Coronary Occlusion | |
| Due to: ✓ | |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. M. D. or other
Address: Lothian, Md. Date signed: 10-8-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

(94a)

09725 21 1

Reg. Dist. Nn. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Magothy Park Road

City or town Annapolis Co md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Anne Arundle Co

City or town Annapolis Co md

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

**3. (a) FULL NAME** Reginald S. Yarbrough.

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | M |

6.(b) Name of husband or wife Nellie Yarbrough

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6. 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 4 | 25 | .....hrs. .....min. |

9. Birthplace Raleigh N. C. (Town, county, and state)

10. Usual occupation Minister

11. Industry or business

FATHER 12. Name Jefferson Yarbrough

13. Birthplace Raleigh N.C.

MOTHER 14. Maiden name Susie Brooks

15. Birthplace Raleigh N. C.

16. Informant Nellie Yarbrough

Address Magothy Park Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5. 1946 (month) (day) (year)

Cemetery or crematory Mt Calvary Cem.

Location Brooklyn Md

18. Funeral director Elroy S. Wilson

Address 5000 Brantley Ave

19. 11/X (Date rec'd by registrar) 1946 A.W. Hedrick Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1946, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| "Coronary occlusion" | Sudden |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Gustave A Paulenoud M.D. acting medical examiner M. D. or other

Address Glen Burnie Md. Date signed 11/1/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

## CERTIFICATE OF DEATH

★ 09726

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Riviera Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? None ( Auto Accident

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Brooklyn, Baltimore, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1133 Monroe Circle

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** EDWARD J. ZIENTEK

**3.(b) Social Security Number:** NONE

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 16, 1927.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 0 | 10 | hrs. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Merchant Marine

11. Industry or business: U.S. Department of Commerce

FATHER — 12. Name: John Zientek

13. Birthplace: Poland.

MOTHER — 14. Maiden name: Agnes P. Lasek

15. Birthplace: Poland.

16. Informant: Walter J. Zientek

Address: 1121 Monroe Circle, Brooklyn 25 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 29, 1946 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: Cedar Hill, A.A.Co., Md.

16. Funeral director: Thomas W. Leighton

Address: Glen Burnie, Md.

19. Oct 28 1946 (Date rec'd by registrar) Mike Alba Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26 1946, at 11.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—

and that I last saw h— alive on ——— 19—

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | Sudden |
| Due to: Fractured Jaw. — | |
| Due to: Bicycle accident. | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10/26/46.

Where did injury occur? Rivera Beach - A.A. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Stony Creek Road.

Means of injury: Collision Injured at work? No

23. SIGNATURE: Gustave H. Pankenburg M.D.

Acting Medical Examiner M. D. or other

Address: Glen Burnie, Md. Date signed: 10/27/46.